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Conservatorship: An Involuntary Legal Status for 'Gravely Disabled' Mentally Disordered Persons

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Since 1969 in California, conservatorship has been the only form of civil, long-term involuntary psychiatric legal process. It does not require hospital-based treatment.

This paper reports a preliminary study of this process through a retrospective analysis of conservatorship records in Sacramento County, California, from 1969 through 1976.

There is a steady overall increase in the incidence of conservatorships each year. A dramatic decrease in state hospital admissions preceded this increase. Referrals were predominantly (69 percent) from the private sector.

Once the first legal step was taken 87 percent of the patients completed the process and were placed on full conservatorship. Median age was 50; 52 percent were male and 90 percent were white. The relative proportion of single persons was high (45 percent). Diagnoses of schizophrenia and organic brain syndrome accounted for 86 percent of conservatees. About half (52 percent) terminate conservatorship after one year. No data were found which could be related to the character of treatment of conservatees. Future research in this area is urgently needed.

IN CALIFORNIA, conservatorship is the only form of civil, long-term, involuntary psychiatric legal process. Unlike provisions of previous commitment laws, it is a process that does not *require* hospital-based treatment. It is a legal process defined by statute under the California Welfare and Institutions Code based upon the concept of "grave disability."

Legislation inaugurating this process was implemented in 1969 with the following intent:

> (a) to end the inappropriate, indefinite and involuntary commitment of mentally disordered persons and persons impaired by chronic alcoholism, and to eliminate legal disabilities; (b) to provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism; (c) to guarantee and protect public safety; (d) to safeguard individual rights through judicial review; (e) to provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons; (f) to encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures.

Conservatorship as a legal status may be granted only to persons who, through judicial process,

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have been determined to be mentally disordered or chronically alcoholic, or both, and who are "gravely disabled"—a condition characterized by inability to provide for the basic necessities of food, clothes and shelter.

Conservatorship action begins when a psychiatrist communicates to the office of the Public Conservator that he had found a person to be "gravely disabled." A Conservatorship Investigation Officer evaluates this report and if sufficient evidence exists, he or she prepares a report to the court indicating that the person is "gravely disabled" due to mental disorder or chronic alcoholism. The person for whom conservatorship status is sought has the right to request either a court or jury trial. Full conservatorship status is granted only after a formal court hearing, but the court may establish a temporary conservatorship on the recommendation of the officer providing conservatorship investigation. In this case, the Public Conservator would be appointed to act as temporary conservator for 30 days, unless the matter is continued by the court.

Conservators may be public officials or private persons (usually a relative) appointed by a judge on recommendation to the court by the Conservatorship Investigation Officer. They are responsible to the court for the person, the person's estate, or both the person and the estate, whichever the court decides. Thus, conservators determine the arrangements for food, shelter and care, and manage the person's estate if the court requires. They are officially charged to give priority to arrangements which would allow the person to return to home, family or friends.

Research literature on conservatorship is extremely sparse, as is research on the more general topic of involuntary psychiatric treatment. (While the "involuntary" status of a psychiatric patient used to be virtually synonymous with admission to hospital, in Sacramento County less than 10 percent of conservatees are residents of a state hospital.) In a study which carefully examines one aspect of conservatorship, Wilbert and coworkers[1] described a method of determining "grave disability" involving occupational therapy-like tasks. The task categories included budgeting, menu-setting, shopping, cooking, clothing and determining job plans, transportation and leisure activities. Acceptance of treatment was also measured. This study indicated that 90 percent of persons with a diagnosis of organic brain syndrome and who were determined by a psychiatrist to be "gravely disabled" failed the tasks. Chronic schizophrenic persons (the majority of cases), however, were much less uniform and only 70 percent failed the tasks that persons in other diagnostic categories (10 percent of the sample) failed only 20 percent of the time. The authors conclude that the test might be useful for persons in diagnostic categories other than organic brain syndrome. Evidence in addition to a psychiatric opinion is clearly important in light of these findings to substantiate the appropriateness of a determination of "grave disability."

The purpose of the present study is to gather basic descriptive data on the actual process of conservatorship so that a foundation may be established for future research in this controversial area. The data include the incidence and prevalence of conservatorship action, as well as demographic, placement and diagnostic data on the Sacramento County conservatorship population as it has been constituted since the 1969 implementation of conservatorship.

Mental Health Services in Sacramento

During the study period there were four principal treatment systems: (1) state hospitals, (2) University of California, Davis, School of Medicine Mental Health Centers, which operated under contract with the Sacramento County Mental Health Department, (3) general hospital based mental health centers and (4) private practitioners. The latter two systems interweave at several levels and for the purposes of referral source data analysis they are combined in the present study under the category "private." The university program administers three (of five) mental health centers in Sacramento County and the only 24-hour crisis service. Referrals from the general hospital mental health clinics are accepted by the university program when private hospital beds are full or their outpatient waiting lists are long. The University Mental Health Centers use a common hospital facility, the inpatient psychiatric unit of Sacramento Medical Center (27 beds at present).

Methodology

All 922 persons placed on conservatorship in Sacramento County from July 1969 through July 1976 were included in this study. Data were gathered from the records of the Public Conservator and from the Supreme Court. Initial referral data including diagnosis, age, race, sex, marital

status, referral source and initial placement were generally available from an up-to-date card file maintained by the Public Conservator's Office. This facilitated the coding of data for computer processing while at the same time ensuring strict confidentiality of individual records. The total sample was adjusted to avoid duplication in those rare cases in which there were multiple separate incidences (as opposed to renewals) of conservatorship action (four cases).

Data for last placement while on conservatorship, number of renewals of conservatorship and year of termination were obtained with considerable difficulty in the case of private conservatees. Approximately 30 percent of the cases had private conservators, and the records were kept at the Superior Court. The data were not summarized in any form and could be obtained only through laborious record review. For public conservatees, these data were available from the card file referenced above.

General population data and vital statistics were secured from county sources. State hospital population data were obtained from the State Department of Health. All adjusted general population rates were based upon 1970 census data.

Results and Discussion

Incidence of Conservatorship Action in Sacramento County

The data presented in Figure 1 show an overall steady increase in the absolute number of persons placed on conservatorship status each year.

In 1969, the first year of the conservatorship program, only 12 persons were assigned to conservatorship status. This rises to a projected high of 286 persons in 1976. Although this was not studied directly, the authors speculate that the increase could be the result of interaction among the following three major factors: (1) increased awareness in the community of conservatorship as a mechanism for dealing with "gravely disabled" persons, (2) changing therapeutic philosophies within community mental health programs in the county and (3) an increase in therapeutic failures in both public and private programs relating to an inability to treat and adequately care for larger and larger numbers of very ill patients who had been discharged from state hospitals to community programs over the years.

Bentz and Edgerton[2] cited community concern over the risk factor created by the existence of psychiatric patients in the community. With these concerns in mind, the present authors were interested in comparing patterns of state hospital admissions and conservatorships with homicide and suicide rates in Sacramento County. The data, as presented in Figure 2, show that although there was a dramatic decrease in state hospital admissions and an accompanying increase in the number of conservatees—that is, more "gravely disabled" persons in the community—there was not a concomitant dramatic increase in either the homicide or suicide rates. It would appear that, at least with regard to the latter two variables, the presence of former state hospital patients and an

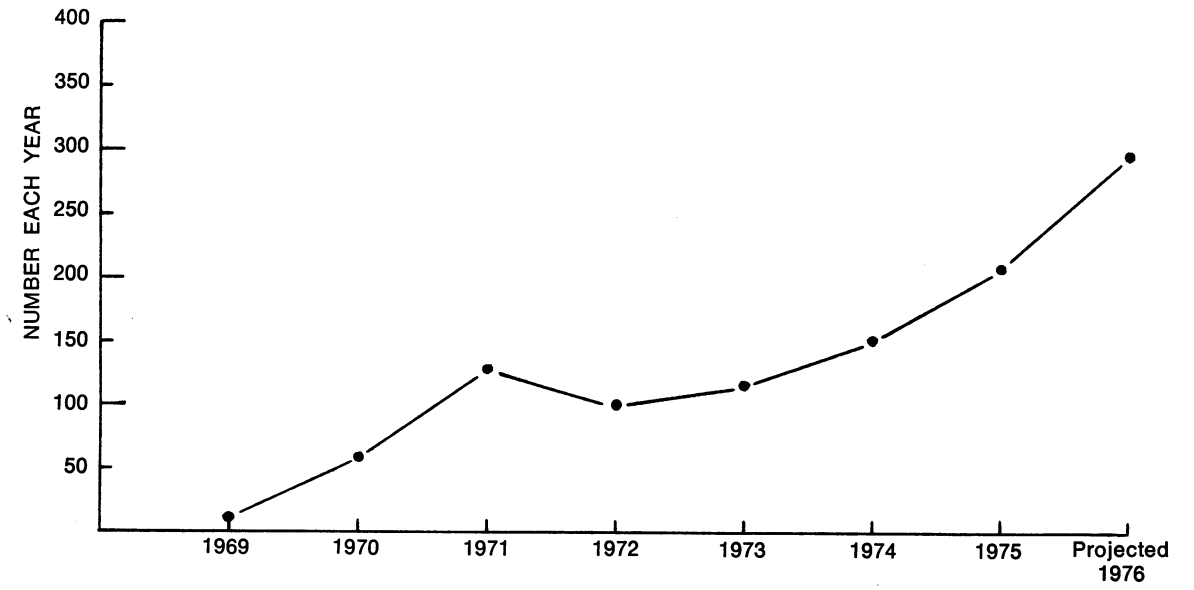

Figure 1.—Frequency distribution of year of assignment to conservatorship among all conservatees (N=922).

increasing number of conservatees in the community does not constitute a major community threat. This is in essential agreement with the findings of a prospective California study.[3]

Source of Referral to Conservatorship

Referral data were available on 920 (99.8 percent) of the 922 cases studied. There were three sources of referral to conservatorship action: (1) the University-based public mental health program, (2) the private sector and (3) state hospitals for the mentally disordered. Since state hospitals accounted for only 12 (1.3 percent) of the cases, this category was eliminated from subsequent analyses relating to referral source and comparisons were made between University-based and private referrals, leaving a data base of 908 (98.5 percent) of the 922 cases studied. Only six-

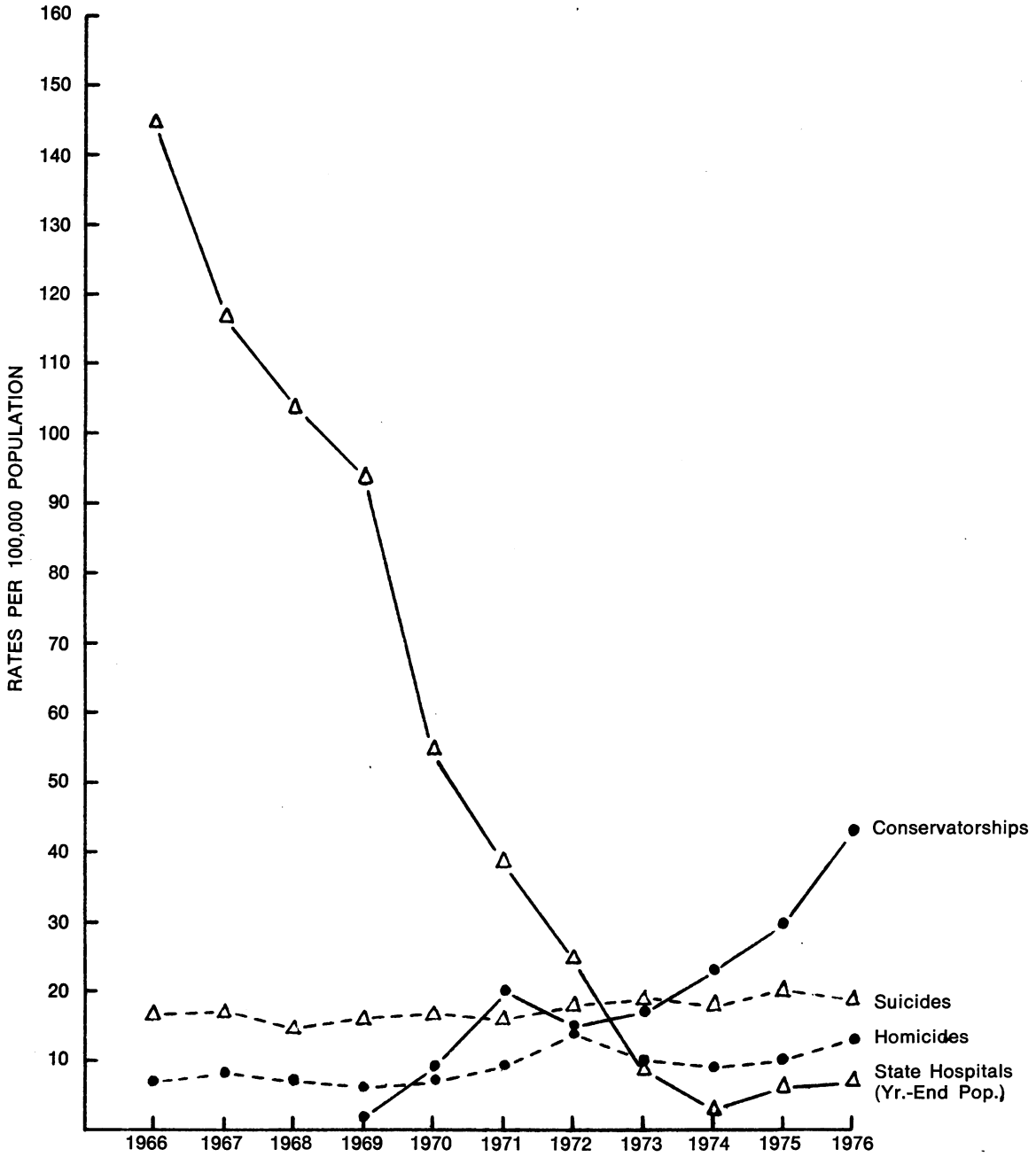

Figure 2.—Sacramento County rates per 100,000 population for state hospital residents, conservatorship actions, homicides and suicides; 1966-1976.

month data were available for 1976 due to the timing of the data collection and analysis.

Over the eight years of this study, 286 (30.7 percent) of the conservatees had been referred to conservatorship action by the university mental health program and 622 (69.3 percent) were referred from the private sector.

The data as presented in Table 1 and Figure 3 show the relative proportions of referrals per year.

The years 1969 through 1971 were characterized by a large influx of state hospital patients into the community following closure of programs at DeWitt and Stockton State Hospitals. Most of the patients who were referred to the university program were treated on a voluntary ambulatory basis through medication and aftercare clinic services. This was due primarily to the strong emphasis placed upon voluntary treatment by the university program at that time. As time progressed, it became possible to identify those patients among the large number of former state hospital patients for whom such voluntary ambulatory care was insufficient or inappropriate. These were then referred for conservatorship action.

In 1973 the shift in the curve was due primarily to the fact that the university program was required by the County Health Agency to evaluate all nursing home residents whose competence or willingness to remain as voluntary patients was questioned by the nursing home administrator. Before this time, patients were evaluated in nursing homes based upon uncooperative behavior or disruptiveness.

TABLE 1.—*Distribution of Major Sources of Referral to Conservatorship Action (N=908)*

	University Based		Private	
	N	%	*N*	%
1969	6	50.0	6	50.0
1970	34	57.6	25	42.4
1971	13	10.6	110	89.4
1972	24	24.0	76	76.0
1973	64	55.2	52	44.8
1974	53	35.1	98	64.9
1975	55	35.9	149	63.1
1976 (6 months only)	37	34.9	106	65.1

Conservatorship Types: Public-Private, Temporary-Full

Public or private conservatorships are categories which distinguish between the types of conservators appointed for a given person. A public conservatorship occurs when a public official (the County Public Conservator-Public Guardian) is

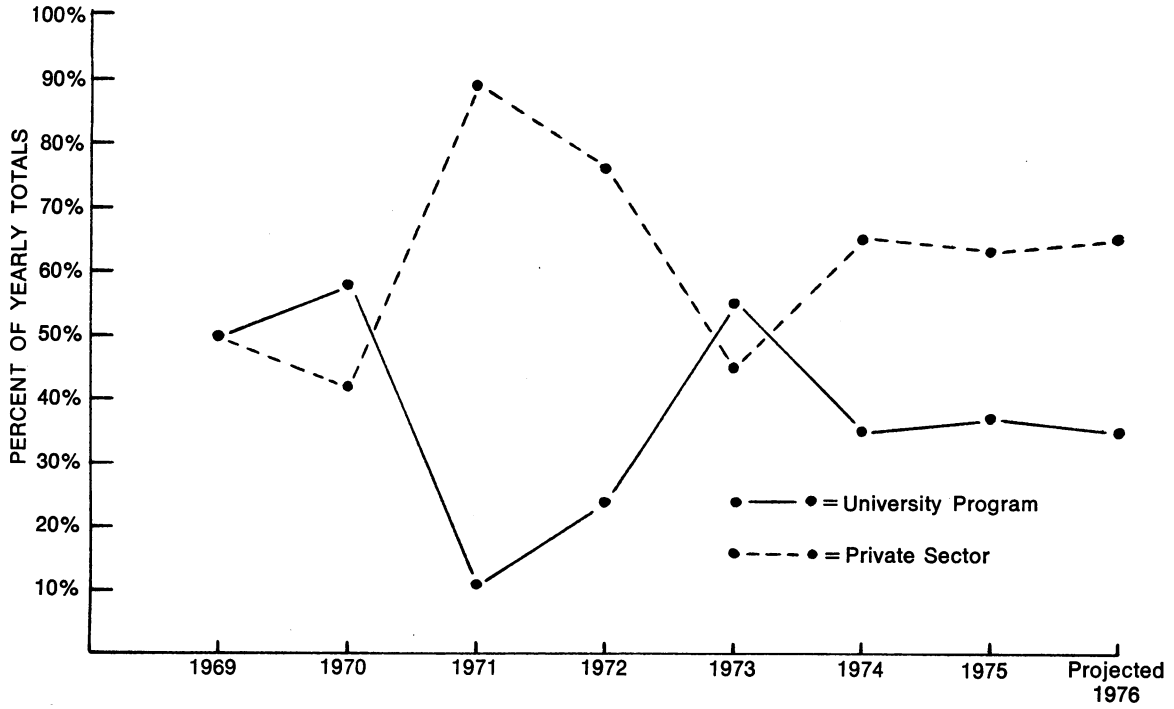

Figure 3.—Percent distributions of source of referral to conservatorship action among all conservatees by year of assignment to conservatorship.

TABLE 2.—*Percent Distribution of Age at Time of Assignment to Full Conservatorship Status (N=800)*

	19 Yrs. and Under	20-29 Yrs.	30-39 Yrs.	40-49 Yrs.	50-59 Yrs.	60-69 Yrs.	70-79 Yrs.	80 Yrs. and Over	Total
N	39	180	96	81	112	106	118	68	800
%	4.9	22.5	12.0	10.1	14.0	13.2	14.8	8.5	100.0

Range = 13-98 years. Median Age = 50 years.

appointed by the court as the conservator. A private conservatorship arises when the court appoints a private person (usually a family member) to act as conservator. In general, the Conservatorship Investigation Officer first attempts to interest a family member in serving as conservator, and only when no one is willing or able to serve does the court appoint the Public Conservator.

Among the 922 conservatorship cases studied, 69.7 percent of the conservatorship actions were public conservatorships, and in 30.3 percent of the cases a private conservator was appointed.

With regard to temporary versus full conservatorships, usually a temporary conservatorship is granted by the court before a decision relative to full conservatorship status. During this period, the Public Conservator's Office will gather data from the psychiatrist or treatment facility with regard to a person's mental health status. In addition, the person's financial status will be determined during this time. When all necessary information has been compiled, a court hearing is scheduled and a decision is reached as to whether or not the person is "gravely disabled" and should be placed on full conservatorship. Each person is represented by counsel of his choice at this hearing.

During the temporary conservatorship period, it sometimes becomes clear that the person is not "gravely disabled," and the Public Conservator may request that the court dismiss the petition. In other instances, a person might successfully challenge the conservatorship action before a judge or jury, with the result that full conservatorship is not imposed. In the present study, 118 (12.8 percent) of the 922 cases received *only* a temporary conservatorship. Cross tabular analysis with other data variables failed to show any significant relationships.

Demographic Characteristics of Conservatees: Age, Sex, Race, Marital Status

The percent distribution of age at the time of assignment to full conservatorship status is presented in Table 2. The age range was 13 through 98 years and the median age was 50 years. Persons aged 20 to 29 years accounted for the peak incidence (22.5 percent) while the next two decades have a relatively low incidence (12 percent and 10 percent, respectively). The low incidence of conservatorship in the middle age range causes one to wonder whether or not "grave disability" is defined differently according to age. An increased incidence in later decades would be expected due to the increasing frequency of severe organic brain syndrome with older ages. Future research might profitably examine this age variable more closely.

Data on sex showed that the relative proportion of males and females in the conservatorship population were virtually equal. Males accounted for 51.9 percent of the conservatees, and females accounted for 48.1 percent.

Racial or ethnic data were available for only 55.4 percent of the cases (511 of the 922 conservatees). The distribution of the 511 cases was as follows: 90.2 percent white, 6.3 percent black, 2.0 percent Spanish surname, 1.1 percent Asian and 0.4 percent American Indian.

Data on marital status showed that the relative proportion of single persons was strikingly high (45 percent), while married persons accounted for only 17 percent of the cases. It appears that the existence of a current marital partner militates against a person being placed on conservatorship.

Cross tabular analysis of marital status data by sex according to selected diagnostic categories showed a few interesting relationships. Among schizophrenic male conservatees 82.9 percent were single while 41.3 percent of schizophrenic female conservatees were single. Single schizophrenics appear to be more likely to be placed on conservatorship than those who are or have been married. The latter is particularly true for males. Conservatees with a diagnosis of organic brain syndrome are more likely to have been widowed, divorced or separated (53 percent). Among women with this diagnosis, 53.9 percent had been widowed (as compared with 13.5 percent for men). It may be that being widowed represents

TABLE 3.—*Percent Distribution of Marital Status Among All Conservatees (N=864)*

	Married	Single	Divorced	Separated	Widowed	Total
N	150	389	145	47	133	864
%	17.4	45.0	16.8	5.4	15.4	100.0

an extraordinary disruption and is a contributing factor to the "grave disability" of females with a diagnosis of organic brain syndrome.

Diagnostic Data

The diagnostic categories indicated in Table 4 are groupings of diagnostic codes based upon the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM-II, 1968). "Affective Disorders" included all of the depressions as well as manic-depressive psychosis. "Other Psychosis" also included nonspecific diagnoses such as "Psychosis-Unknown Etiology" and "Paranoid States." It is clear from the distribution of diagnoses that those diagnostic categories representing the greatest degree of impairment are most heavily represented among the conservatees. The schizophrenia and organic brain syndrome categories account for 86 percent of the conservatees. This is what one would expect in a process whose definition is based upon a person being "gravely disabled."

Placement Data

"Last placement," as used in this study, refers to the place where the conservatee was located either at the time the data were collected or when the conservatorship terminated, whichever occurred first. Table 5 shows that nursing homes together with board and care homes accounted for 62.6 percent of all placements, while state hospitals accounted for only 9.7 percent. The largest proportion of conservatees (43 percent) had been placed in nursing homes. It will be important in future research to examine relationships between placement and such variables as diagnosis and public or private conservatorship status, as well as movement patterns between facilities and programs.

Renewals of Conservatorship

Conservatorship status for any given person is reviewed annually and, as a result of court action, is either renewed for an additional year or terminated. The data as presented in Table 6 indicate the number of renewals of full conservatorship according to the year that the persons

TABLE 4.—*Percent Distribution of Diagnostic Category Among All Conservatees (N=922)*

	Schizophrenia	Organic Brain Syndrome	Affective Disorders	Other Psychoses	Neuroses	Alcoholism	Other Personality Disorders	Total
N	507	286	32	81	4	41	21	922
%	55.0	31.0	3.5	3.4	0.4	4.4	2.3	100.0

TABLE 5.—*Percent Distribution of Last Recorded Placement at Time of Study Among All Conservatees (N=904)**

	Nursing Home	Board and Care Home	State Hospital	At Home	Jail	Other Placement	Absent Without Leave	Total
N	389	177	88	140	4	84	22	904
%	43.0	19.6	9.7	15.5	0.4	9.3	2.4	99.9

*Includes persons who died while on conservatorship or who had been discharged from conservatorship at the time of the study.

TABLE 6.—*Renewals of Conservatorship by Year of Original Conservatorship Action (N=482)*

	Number of Renewals of Conservatorship*													
	None		1		2		3		4		5		6	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
1969 (12)	9	75	0	0	0	0	1	8	0	0	1	8	1	8
1970 (56)	30	54	6	11	5	9	3	5	3	5	9	16	..	..
1971 (105)	41	30	15	12	13	11	16	13	23	19	..	..	..	..
1972 (93)	52	54	9	9	13	14	19	20	..	..	..	..	..	..
1973 (92)	53	46	8	7	38	33	..	..	..	..	..	..	..	..
1974 (124)	77	51	47	31	..	..	..	..	..	..	..	..	..	..

*Two dots (..) appear where there has been insufficient time for all possible renewals to occur.

were placed on conservatorship. The table is structured to reflect the fact that (at the time of data collection) there had been insufficient time for all possible renewals. Consequently, data are reported on 482 conservatees who were on full conservatorship and who had a chance to renew by the time of the study. It appears that on the average approximately 52 percent of all conservatees terminate conservatorship at the end of the first year. Based on the original conservatorship years 1970 through 1972 (where enough time has elapsed to analyze sufficiently), of those who renew conservatorship, approximately 10 percent of the original total number terminate each year thereafter. (We should point out that some of the terminations are due to the death of the conservatee, and the data have not been corrected to account for this. Only 9.5 percent of the total conservatorship population, however, had died while on conservatorship.) After the first year, only about 10 percent of the original number of conservatees renew *only* once. Therefore, if conservatorship status for a given person is not terminated at the end of the first year, there is a fairly high probability that conservatorship status will continue for at least two more years. Future research should definitely be devoted to identifying those variables which characterize the persons for whom conservatorship is renewed—that is, whose involuntary status is prolonged—compared with those persons who terminate conservatorship at the end of one year.

Treatment of the Conservatee

Essentially no data were found that could be related to the character of treatment received. Participation in programs such as outpatient psychotherapy, day treatment, vocational rehabilitation, activities programs and job training was not uniformly recorded in the records. Social functioning was not described at all and work status was rarely noted. Further, there is wide variability in the therapeutic programs of different nursing homes and board and care homes in Sacramento County.

A key assumption by authors who favor involuntary treatment is that involuntary treatment is beneficial to the persons so treated.[4-7] Unfortunately, only a few studies have examined the outcome associated with short-term involuntary treatment,[8-10] while extended involuntary treatment remains unstudied.

Polemical opinions dominate the psychiatric and legal literature with Szasz[11] and others, at one extreme, denying the appropriateness of involuntary treatment under any circumstances, and Treffert[12] and others, on the other extreme, saying that there is gross neglect of seriously disturbed patients which results in their "dying with their rights on."

Discussions

Data on conservatorship obtained through retrospective record review are inadequate to answer any of the fundamental questions about the propriety and effectiveness of involuntary treatment. Such data, however, do provide descriptions of both process and conservatee characteristics. These descriptive data become the source of a wide variety of interesting and important questions for future research.

Specific areas identified for more rigorous research are: (1) refinement and measurement of the concept of "grave disability," (2) comparison of conservatees with persons referred but not placed on conservatorship, (3) comparison of differential characteristics of "private" versus "public" referrals, (4) comparison of age groups with special attention paid to the possibility that "grave disability" is in practice defined differently according to age, (5) relationships between various characteristics of conservatees and their initial placement and, most important, (6) carefully designed treatment outcome studies.

Prospective research studies of the type suggested above require time, attention to ever present sources of bias and a major commitment of financial resources. The almost total lack of data on conservatees and the conservatorship process indicates how little attention has been paid to the important medical and legal questions surrounding this subject.

The medicolegal problem of the involuntary treatment of persons is of long standing and only successive approximations can be made toward its solution. Since institution of wide-ranging reform in mental health legislation was effected in California in July 1969 (Lanterman-Petris-Short Act and revision of 1957 Short-Doyle legislation), processes such as indeterminate judicial commitment have been stopped, new processes instituted and old institutions redefined. Conservatorship, or in essence the vesting of physical and financial responsibility for the gravely disabled conservatee by the court either in a publicly appointed con-

servator or a court-appointed volunteering private citizen for one year, subject to renewal by the court yearly, is one of these new institutions. Conservatorship changes involuntary treatment from an all-or-none phenomenon into a time-bound process, while also protecting the right of due process. These time limitations define and provide appropriate boundaries for rigorous scientific study.

A scientific appraisal of all involuntary treatment procedures is vital for the psychiatric profession. Much of the force of argument for a medical model for the determination of involuntary treatment rests with the implied benefits of treatment. Since the benefits of involuntary treatment remain controversial[11-13] and essentially unmeasured, scientific appraisal will not be an easy task. This, however, should not deter us from continued study of the process.

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Treatment of Legionnaire's Disease

THE ONLY WAY you can make the diagnosis is to suspect it and treat it empirically. The treatment of choice is probably erythromycin in a dose of 0.5 to 1 gram every six hours. That can be given intravenously, if necessary, or orally. The drug is rather irritating when given intravenously, so if the patient can take the medication orally, that's fine. The data that give us that information were from a challenge study in which guinea pigs were infected with the organism and then treated with various antibiotics. Erythromycin is by far the most effective . . . The same can be shown in tissue cultures and it can also be done on the agar plate much as the sensitivity testing is done in routine laboratory studies. However, the antibiotic susceptibility data generated that way indicate that the organism looks susceptible to many antibiotics. Clinically we know from the Legionnaire's outbreak, and related data, that many of those antibiotics are not effective in the therapy of this disease. So there still is some question about what other antibiotics would be appropriate. At present, erythromycin is the only really good choice; it is not clear what would be a second choice drug.

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